Georgetown
Physical and Sports Therapy Clinic
83 Mill Street, Suite B, Georgetown, ON L7G 5E9
(905) 877-8668 – Fax (905) 877-4165

HEALTH QUESTIONNAIRE

Personal Information:

Name: _____
Date of Birth: _____
Gender: ⬭ Male ⬭ Female
Address *(including postal code)*: _____
Telephone numbers: Primary _____ Other _____
Email: _____

Family Doctor: _____ City/Town: _____
Referring Doctor, *if different*: _____ City/Town: _____

Insurance policy: ⬭ Yes ⬭ No
If yes, Insurance Company: _____
Name and Date of Birth of Insured, if different from above: _____
Policy # _____ Member ID/Certificate # _____

Employment Information:

1. Are you currently working? ⬭ Yes ⬭ No

If yes, ⬭ Full duties ⬭ Modified duties
If no, ⬭ Off work ⬭ Unemployed ⬭ Retired ⬭ Student
⬭ Because of injury/condition

Job title/ description:
_____
_____

Accident History and Medical Information:

2. Briefly describe your injury:
_____
_____

3. Date of accident/injury: _____

4. Have you done any tests, X-rays? ⬭ Yes ⬭ No *If yes*, what were the results?
_____

5. Are you taking any medications for your current condition? *Please specify.*

_____

6. Did you receive treatment previously for this condition/injury? *If yes*, please explain.

_____

_____

7. Do you suffer from any of the following diseases:

⬭ Lung problems	⬭ Kidney problems	⬭ Cancer	⬭ Allergies
⬭ Headaches	⬭ Digestive problems	⬭ Neck/back pain (recurrent)	
⬭ Depression	⬭ Anxiety	⬭ Other Musculoskeletal problems	
⬭ Sleep disturbances	⬭ Shortness of breath	⬭ High/low blood pressure	
⬭ Diabetes	⬭ Other_____		

If yes to any of the above, please provide details:

_____

_____

8. In the past, have you had surgeries, motor vehicle accidents, work or sports-related injuries that may be relevant to your present condition?

If yes, please provide details of the condition and treatment prescribed (if any).

_____

_____

9. Do you have any metals in your body? i.e. pins or plates (fillings do not count).
⬭ Yes ⬭ No

10. How is your general health? ⬭ Excellent ⬭ Good ⬭ Fair ⬭ Poor

11. Do you use a pace-maker? ⬭ Yes ⬭ No

12. *For ladies only,* are you pregnant? ⬭ Yes, months _____ ⬭ No

13. How did you hear about our clinic? (please circle all that apply)

⬭ Previous client	⬭ Doctor	⬭ Phone Book	⬭ Newspaper
⬭ Friend/Word of Mouth	⬭ Google	⬭ Website	⬭ Yellow Pages Online
⬭ Other _____			

I hereby confirm that the above information, to the best of my knowledge, is correct.

_____ _____ _____

Signature **Signature of parent** **Date**
(If patient is under 18 years old)